Phoenix Care Homes Limited

Phoenix House

Inspection report

The Drove
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

Phoenix House provides accommodation and personal care for up to 24 people who need support with their mental health needs. There were 19 people living at the service at the time of the inspection. The service is situated in its own extensive grounds and gardens in the rural village of Northbourne, which is close to the seafront towns of Deal and Sandwich.

The care and support needs of the people varied greatly. There was a wide age range of people living at the service with diverse needs and abilities. The youngest person was in their 40's and the oldest was in their 70's years.

As well as needing support with their mental health, some people required more care and support related to their physical conditions. Most people were able to make their own decisions about how they lived their lives. They were able to let staff know what they wanted and were able to go out on their own.

The previous inspection of this service was carried out on 3 November 2015 when we found breaches of some regulations. The provider sent an action plan to CQC in December 2015 with timescales stating they would be compliant with the regulations by December 2015. At this inspection the provider had failed to comply with their action plan and there were continued breaches of the regulations relating to safe care and treatment, the recruitment of staff, treating people with dignity and respect that promoted their independence and autonomy and good governance.

There was a registered manager working at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A deputy manager had recently been appointed to support the registered manager.

At the previous inspection staff were not always recruited safely, at this inspection there still shortfalls. The provider had policies and procedures in place for when new staff were recruited, but these were not consistently followed. All the relevant safety checks had not been completed before staff started work.

Some care plans did not contain all the information needed to make sure people received the care and support that they needed. The process of reviewing and updating people's care plans had fallen behind due to staff shortages and the registered manager had spent a lot of their time working with the care staff team to make sure people's daily needs were met. A staff member had now been employed to make sure people's care plans were reviewed and updated, however the care plans were written in negative way and indicated that staff controlled the way people behaved. People were not always empowered to have as much control and independence as possible with aspects of their lives. People had not been fully involved in reviewing their care plans and how they wanted to receive their care and support. People were not always treated with dignity and respect that promoted their independence and autonomy

Potential risks to people were identified, like diabetes, eating safely and when people had behaviours that could be challenging. Full guidance on how to safely manage the associated risks was not always available. This left people at risk of not receiving the support they needed to keep them as safe as possible. Accidents and incidents had been recorded and action had been taken to reduce any risks to people.

Generic emergency plans were in place so if an emergency happened, like a fire, the staff knew what to do. However, personal emergency evacuation plans (PEEPs) were not adequate and did not contain information about people's individual needs during an emergency evacuation. This was identified as breach of the regulations at the last inspection and continues to be a breach at this inspection. It had been identified that emergency lightening was not working but this had not been fully repaired.

At the time of the inspection people had their needs met by sufficient numbers of staff. The provider had recently employed new staff and when there were shortfalls agency staff were employed. However, we were told there had been a long period of time in 2016 when there had not been enough staff and although this did not have a direct impact on people; it had impacted on the other aspects of the service including audits. There were quality assurance systems in place which included reviewing and updating care plans, audits, health and safety checks, but these had not been consistently undertaken by the registered manager due to other work pressures. Audits had not identified some shortfalls that were identified during the inspection.

Staff numbers were based on people's needs, activities and health appointments

Since the last inspection many of the established staff team had left the service. They said they found this 'unsettling and confusing' and were unsure 'what was happening'. People told us that they were not going out as much as they used to and missed going places and doing different activities. People were involved in some activities which they enjoyed. Some people were able to go out daily and do what they wanted to in the local area. People did art and crafts, as well as other leisure activities within the service.

Established staff had built up relationships with people and were familiar with their life stories, wishes and preferences. Staff knew how people preferred to be cared for and supported and respected their wishes. People were getting to know the new staff and visa versa so that new positive relationships could develop. Contact with people's family and friends, who were important to them was well supported by staff.

Before people decided to move into the service their support needs were assessed by the registered manager to make sure they would be able to offer them the care that they needed. The care and support needs of each person were different and each person's care plan contained information that was personal to them.

People felt safe in the service. Staff understood how to protect people from the risk of abuse and the action they needed to take to report any concerns in order to keep people safe.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

The way people received their medicines had changed and improved since the last inspection. Each person was now supported to be more independent when taking their medicines and their dignity was respected when they were given their medicines.

At the last inspection the provider had not taken all the necessary steps to make sure all staff were suitably

qualified, competent skilled and experienced to work with people, at this inspection improvements had been made. Staff had completed induction training when they first started to work at the service and had gone on to complete other basic and specialist training provided by the company.

Staff had support from the registered manager to make sure they could care safely and effectively for people. Staff said they could go to the registered manager at any time and they would be listened to. Staff had received regular one to one meetings with a senior member of staff and an annual appraisal.

People said that they enjoyed their meals. People were offered and received a balanced and healthy diet. People had support to manage their physical and mental health needs.

The complaints procedure was on display in a format that was accessible to people. Feedback from people, their relatives and healthcare professionals was encouraged and acted on wherever possible. Staff and people told us that the service was well led and that the management team were supportive and approachable. They said there was a culture of openness within Phoenix House which allowed them to suggest new ideas which were often acted on.

At the last inspection the service was rated 'Requires improvement'. Although there had been changes in some areas there continued to be breaches of regulations and the rating remained at 'Requires improvement'.

We found continuous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and new breaches of the regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Recruitment procedures were in place but were not fully adhered to before new staff started to work with people.

Risks to people were assessed but there was not always full guidance to make sure all staff knew what action to take to keep people as safe as possible.

The management of medicines had improved but there was no guidance in place for when people needed medicines for when they were restless or agitated.

Staff knew the signs of abuse and how to report any concerns.

There were enough staff on duty to make sure people received the care and support they needed.

Is the service effective?

Requires Improvement

The service was consistently effective

Staff had received the training they needed to meet people's needs. However, the guidance in the care plans was not in line with best practise and there was a risk that there might be inconsistent and conflicting approaches by staff.

Staff felt well supported by the registered manager and the staff team.

The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Applications had been made when people's liberties were restricted

When people had specific physical or mental health needs and conditions, the staff had contacted healthcare professionals and made sure that appropriate support and treatment was made available.

People and their representatives were involved in making

decisions about their care and support.

People were provided with a suitable range of nutritious food and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect that promoted their independence and autonomy.

Staff communicated with people in a caring and compassionate way.

People and their relatives were able to discuss any concerns regarding their care and support. Staff knew people well and knew how they preferred to be supported. People's privacy was supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive the care and support they needed to meet their individual needs. People's preferences, likes and dislikes were taken into consideration in aspects of their care.

People were able to undertake daily activities but they said they did not do as much as they used to. People had some opportunities to be part of the local community.

People and their relatives said they would be able to raise any concerns or complaints with the staff and registered manager, who would listen and take any action if required.

Is the service well-led?

Inadequate

The service was not consistently well led.

There were systems in place to monitor the service's progress using audits and questionnaires. Some audits and checks had not been carried out consistently. Some shortfalls not been actioned or identified. The service had not improved or developed.

The staff were aware of the service's ethos for caring for people as individuals and putting people first. The registered manager led and supported the staff in providing compassionate and sensitive care for people, and in providing a culture of openness and transparency.

People said that they felt listened to. There was a commitment to listening to people's views.

Phoenix House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 December 2016 and was unannounced. It was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or a serious injury.

We met most of the people living at the service and had conversations with five of them. We spoke with four members of staff, the registered manager and two visiting professionals at the inspection. Before the inspection we spoke with a visiting professional who had contact with the service.

During our inspection we observed how the staff spoke with and engaged with people. We looked at how people were supported throughout the day with their daily routines and activities. We reviewed five care plans of the people living at the service, and looked at a range of other records, including safety checks, records kept for people's medicines, staff files and records about how the quality of the service was managed.

We last inspected this service on 3 November 2015 when breaches in the regulations were found.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Phoenix House. They said there was always staff around if they needed anything or if they needed to talk. People said, "I have lived here for a long time and the staff are always kind. The staff are always nice to me and I'm very happy living here" and "Staff do the best they can here, I like living here. I wouldn't change anything".

Visiting professionals said, "We often place people here as we know they will be safe and cared for".

At our inspection in November 2015 we found that the provider had not completed safety checks to make sure staff were safe to work with people. They sent us an action plan in December 2015 saying they had addressed this. At this inspection we looked at six staff files, two of them only had one reference in place and gaps in employment history had not been fully explored. One staff file did not contain a full employment history. The staff involved had all been recruited since the last inspection. The lack of full employment checks left people at potential risk of being cared for by staff that may not be safe to work with people.

The registered person had not ensured that all the information was available as required by Schedule three of the Regulations before new members of staff started work. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other safety checks had been completed including Disclosure and Barring System (DBS) checks. (The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services). Successful applicants were required to complete an induction programme and probationary period.

At the inspection in November 2015 the personal emergency evacuation plans (PEEPs) were not adequate and did not contain information about people's individual needs during an evacuation. The registered manager sent us an action plan in December 2015 saying they had addressed this. At this inspection there were still shortfalls. Three people did not have a PEEP's available. The other PEEP's had limited information about how to support people in an emergency. Some people needed assistance with mobilising in case of a fire but there was no detail of the assistance needed. Some people could become anxious or distressed as a result of a fire alarm but there was no guidance for staff about how to support people to reassure them and make sure they were as safe as possible.

An outside agency had checked the emergency lighting in October 2016 and advised that two units were not working, on the day of the inspection only one of these had been repaired. This could cause a risk to people leaving the service in an emergency.

There was a risk that people's safety, in the event of a fire, may be compromised. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was fitted with fire detection and alarm systems. Regular checks were carried out on the fire

alarms and other fire equipment to make sure it was working. The service had recently replaced fire doors following a fire risk assessment. Special precautions had been put in place when increased risks to people had been identified, like fire retardant sheets, extra fire extinguishers and extra staff checks.

Staff and people were involved in monthly fire evacuation drills, this included one at night as advised by the fire officer. Regular maintenance checks were made on systems like the boiler, the fridge and the electrics and gas supply. Equipment had been serviced and regularly checked to make sure it was in good working order.

At the last inspection people were at risk of not receiving all their medicines safely and consistently. At this inspection improvements had been made. Each person now had an individual medicine cabinet in their bedrooms so that they received their medicines in private and in a way they preferred. Staff felt this was a safer way to give people their medicines and reduced the risk of mistakes being made.

People said they received their medicines safely and on time. People's medicines were managed by staff and there were plans in place to support people to be more independent when taking their medicines. All medicines were stored securely and staff had received training in medicine administration, which was refreshed every year. Direct observation checks were also carried out on staff when they were giving people their medicines to make sure they were doing it safely and were competent. Medicines which required being stored in cooler temperatures were stored in a fridge. Temperatures were recorded in all the rooms were medicines were stored and these were within the recommended ranges. Some people were prescribed medicines which required regular and close monitoring by having regular blood tests. People were supported to attend planned appointments to have their blood tests.

Some people were given medicines on a 'when required basis', these were medicines for pain like paracetamol or medicines to help people remain calm. People were asked by staff if they were in pain and if they needed any 'pain relief'. There was guidance for each person who needed 'when required medicines' for pain and staff checked that the pain relief medicines were working effectively. For other 'when required' medicines some of the guidance did not fully explain when and why the person should receive the medicine. There was a risk that people may receive their 'when required' medicines inconsistently. The staff who gave people their medicines were able to explain when they gave people 'when required' medicines. They were clear and consistent about when they gave people these medicines. The effects of the medicines were monitored to see if they were working for the person. If they were not effective then this was reported to the person's doctor and further advice was sought.

We recommend that the provider should take into account The Royal Pharmaceutical Society of Great Britain Guidelines with regard to the administering of 'when required' medicines.

The medicines given to people were accurately recorded. Hand written entries of medicines on the MAR charts had not always been consistently countersigned to confirm that the information was correct and to reduce the risk of errors. This was an area for improvement.

There was evidence of stock rotation to ensure that medicines did not go out of date. Bottles of medicines were dated when they were opened so staff were aware that these items had a shorter shelf life than other medicines, and this enabled them to check when they were going
out of date. Regular checks were done on the medicines and the records to make sure they were given correctly. If any shortfalls were identified the registered manager took immediate action to address them.

Risks to people had been identified but the guidance on how risks should be managed varied. Some risk

assessments contained the information needed to keep people as safe as possible but other risk assessments did not. Risk assessments needed to be developed for people who had conditions like diabetes. There was a lack of clear guidance about what action the staff should take if a person's condition became unstable and their blood sugar became too high or too low. and what signs they should look for. The established staff were able to explain clearly the signs they would look for and the action they would take. On the day of the inspection a person's blood sugar became unstable and the staff on duty took the appropriate action to make sure the blood sugar returned to normal.

Some people sometimes became upset or agitated. In one person's care plan there was no clear guidance to explain to staff how they should support people consistently in a way that suited them best. Staff were able to say how they would support people and we observed this at the inspection. Staff went to people and re-assured them. They spoke to them quietly and calmly. They stayed with them until they felt better. The shortfalls in the risk assessments had not had a direct impact on people. However, because the service had recently employed new staff and was using agency staff there was a risk that staff would not take the appropriate action to keep risks to a minimum as there was insufficient guidance.

We recommend the provider review their risk assessment documentation to ensure it has enough detail and is up to date.

When people needed support to mobilise and move around the service or needed support with their diet there was guidance in place on how to do this safely. There were risk assessments for when people went into the local community and for using transport. People could access the community safely on a regular basis. When some people were going out, they received individual support from staff.

There were risks assessments in place for when people smoked. Potential risks were assessed so that people could be supported to stay safe.

Accidents and incidents were recorded by staff. The registered manager assessed these to identify any pattern and took action to reduce risks to people. Incidents and accidents were discussed with staff so that lessons could be learned to prevent further occurrences.

People said that if they were not happy with something they would report it to the registered manager. They were confident that they would listen and take action to protect them. Staff knew people well and were able to recognise signs if people were upset or unhappy. Staff explained how they would recognise and report abuse. They had received training on keeping people safe. They told us they were confident that any concerns they raised would be taken seriously and fully investigated to ensure people were protected.

Referrals had been made to the local safeguarding authority when safeguarding incidences had happened. Staff were aware of the whistle blowing policy and knew how to take concerns to agencies outside of the service if they felt they were not being dealt with properly.

In 2016 a lot of the established staff team at Phoenix House had left. Staff and people told us that there had been a period of time of about seven to eight months when there was not enough staff. Staff said that they had to cover a lot of extra shifts and the registered manager spent a lot of time working with them to make sure people were safe and getting the care and support that they needed. They said this was a difficult time but the situation was now improving as new staff were being employed and they were using agency staff to cover shortfalls. A deputy manager had recently been employed to support the registered manager.

Staff told us they felt there was enough staff to keep people safe. One staff member said, "We work well as a

team and that means we get things done." There was one senior staff or team leader and three carers on duty during the morning and afternoon. The provider also employed a cleaner and a cook. At night there was one staff member awake and one asleep who could be called on in an emergency.

People said, "Sometimes there are not enough staff to take us out, we used to go out more than we do at the moment" and "Staff are too busy to take us out to see the outside world but I think things are getting better".

There were staff vacancies at the service and some shifts were not fully covered, this sometimes limited some people's access to activities. The staff rota showed six shifts over a two week period, one week before and one after the inspection, when there was not enough staff on duty even when agency staff were being used. Regular agency staff were used to help provide consistency for the people in the service. The registered manager had worked alongside staff when needed to keep people safe but this meant the registered manager did not have the time to carry out their managerial responsibilities.

Requires Improvement

Is the service effective?

Our findings

People said, "The staff work very hard to make sure we are all looked after", "We can sit down and chat to any of the staff whenever we want" and "They listen to what I have to say and try and sort everything out, they are good".

Staff told us they had regular training and felt confident supporting people. One staff member said, "We seem to always be doing some training, if there is anything I am worried or unsure about I speak to the manager and they can arrange more training for me".

At the last inspection the provider had not taken all the necessary steps to make sure all staff were suitably qualified, competent, skilled and experienced to work with people. At this inspection improvements had been made. Action had been taken to make sure staff had the training they needed to perform their role. The registered manager kept a training record which showed when training had been undertaken and when 'refresher training' was due. This included details of some courses related to people's specialist needs like diabetes and behaviours that challenge. Most of the staff had now completed this training and were able to explain how these conditions might affect people. People required care and support with their individual conditions linked with mental health and staff had received this training. Staff were able to tell us how they would care and support people living with mental health conditions.

Staff told us they felt supported and that the training they had completed was essential to their role. Staff were knowledgeable about the training they had received. Some staff were able to explain about the training they had attended and how they put this into practice when caring and supporting people. For example staff knew what to do if people's diabetes became unstable, they knew what signs to look for when peoples mental health was deteriorating

Regular training updates were provided in subjects, such as, moving and handling, first aid, infection control and fire safety.

Although staff had attended this training, records, including care plans that staff followed, were not written in line with best practice. Behaviour care plans instructed staff to control some people by withdrawing things like cigarettes, another care plan instructed staff to be confrontational 'if they needed to be'. Without respectful person centred guidance to follow, staff relied on intuition and each other to give the right support. With some new staff in post who had not completed all of the training and the use of agency staff there was a risk of inconsistent support.

When staff first started working at the service they completed an induction and a probationary period. This included shadowing experienced staff to get to know people and their routines. Staff were supported during the induction, monitored and assessed by the registered manager to check that they were able to care for, support and meet people's needs. Regular staff meetings and handovers highlighted people's changing needs, household tasks allocations, and reminders about the quality of care delivered. Staff had the opportunity to raise any concerns or suggest ideas.

The established staff team knew people well and knew how they liked to receive their care and support. The staff had knowledge about how people liked to receive their personal care and what activities they enjoyed. Staff were able to tell us about how they cared for each person on a daily basis to ensure they received effective individual care and support. They were able to explain what they would do when people's moods changed and the signs they look for to make sure people were receiving the amount of support that they needed.

Staff told us that they felt supported by the registered manager and the deputy manager. They said that they were listened to and were given the support and help that they needed on a daily basis. Staff had regular one to one meetings with the registered manager or senior member of staff. Staff had an annual appraisal which identified their development and training needs and set personal objectives.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The majority of the people living at Phoenix House had full capacity to make their own decisions about how they lived their lives and this was respected by the staff.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager of the service had knowledge of the Mental Capacity Act 2005 (MCA) and the changes to the legislation. They had recently had more training in Mental Capacity and DoLS. They had considered people's mental capacity to make day to day decisions and there was information about this in their care plans. There were mental capacity assessments in place to determine whether people had capacity or not to make decisions but these had not been consistently completed for when people's capacity to make decisions fluctuated. People had not been included in reviewing and updating their care plans. Some strategies like withdrawing support had been introduced but people had not been involved in this decision and had not agreed to it.

When people's behaviour changed and there were changes made to their medicines, these decisions were made by the right clinical specialists with input from relatives and the staff. If people lacked capacity to give consent to these changes there was a mental capacity assessment available and best interest decision making was recorded.

Advocacy support was available for people when they needed to make more complex decisions. In the past Independent Mental Capacity Advocates, (IMCA - an individual who supports a person so that their views are heard and their rights are upheld) had been involved in supporting people to make decisions in their best interests. Even though the majority of people had full capacity there were some restrictions in place. People could not go in and out of the service as they wished as the front door was locked and only staff had the keys. People also could not access the kitchen when they wanted to as it was locked and they had to ask staff for drinks and snacks. The registered manager and staff told us these restrictions were in place as it was 'too risky' for people. People would benefit from reviewing these restrictions to make sure they were the least restrictive options.

We recommend that any imposed restrictions are reviewed to ensure they are the least restrictive option.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. The staff actively sought support when people needed it and did not work in isolation. People were supported to make and attend medical appointments. People's health was monitored and care provided to meet any changing needs. When people's physical and/or mental health declined and they required more support the staff responded quickly. Staff contacted local community healthcare professionals and made sure that the appropriate treatment, care and support was provided.

People were supported to go to the GP, dentist and optician; appointments had been made for blood tests when people were on special drugs where they needed to have their blood levels monitored. Staff made appointments with the consent of the person and when asked were happy to accompany people to these appointments.

People and staff told us that there was good communication between everyone. Visiting professionals said that there was clear and effective communication with the staff. Regular reviews were held when people's care was discussed in full and the staff were able to provide documentation if there had been any issues. Staff sought advice and support if they were unsure how to manage certain situations and in regard to more complex mental health issues.

One person said, "The food is beautiful. We have a brilliant chef. You can more or less have anything that you want". People told us the food was good and there was always a choice. If people did not like the choices then they could have something else. The chef had talked with people about the food that they liked and preferred.

The lunchtime meal was a social occasion when people sat together and chatted. There was a relaxed and friendly atmosphere. People were supported and encouraged to eat a healthy and nutritious diet. People were able to have their meals when they wanted them. Some people preferred to get up later and have a late breakfast.

Some people had tea and coffee making facilities in their rooms so they could be more autonomous and independent. Sometimes people chose to eat out in local restaurants and cafés.

Special diets were prepared for people. Softened or supplement foods were provided when it was necessary. When people were not eating or drinking enough their diet and fluids were recorded and monitored and action was taken if any concerns were identified. The meals were well presented with ample portions. Staff were sensitive and discreet when they supported people to eat. They supported people to eat at their own pace and to enjoy the meal.

Requires Improvement

Is the service caring?

Our findings

People said they were well cared for and staff treated them well. People said, "Considering what I went through before I came here, this is a good place to be. We are just people here and treated properly. The staff are good and kind" and "I have visited other places but I choose to live here. It's home to me".

One member of staff told us: "Everyone, staff and clients get on well; we all respect and like each other". Other staff said that they made sure that they included people in all aspects of the day; they said that they treated everyone the equally and fairly.

Visiting professionals told us that their experience of working with the people and staff at Phoenix House was a positive one. They had witnessed people being treated with respect and dignity and said that people received the support that they needed.

Some staff did not always treat people with respect, including the language they used when they spoke about people and wrote in their records. One person's care plan stated, 'Uses lack of personal presentation and hygiene as a control issue!!' and 'Staff will not give xxx what they want until they calm down and act appropriately'. Staff had not considered that the language they used to describe people might be disrespectful. This was discussed with the registered manager who was unaware that the care plans had been written in this way. The registered manager agreed that this was an unacceptable and disrespectful way of writing about people and would review the care plans that had been rewritten.

People were not always supported to be as independent as they could be. The provider stated in their statement of purpose that the service offered a rehabilitation service for people. However, we found that opportunities for people to rehabilitated and develop their skills were limited. People had no access to the kitchen which was kept locked at all times. Staff said this was because of the risks the kitchen equipment posed to people. Staff said, "No-one helps or is allowed in the kitchen".

People had to request drinks and snacks from a kitchen hatch. They were not involved in preparing meals, drinks or snacks. People said, "The cook and the staff do all that". Some people told us they would like to be more involved with preparing and cooking meals. The registered manager told us that the plan was to develop a kitchen area for people in a different part of the service to they could be more involved in food preparation but there was no plan or timescale in place for when this would happen. Some people, but not all, had tea and coffee making facilities in their rooms so they could make their own drinks. Some people said they did not use the facilities in their rooms as it was easier if someone else made their drinks for them.

The front door of the service was double locked at all times and the key held by staff. People had to request to be let in and out of the service. Some people could come and go as they pleased but the locked door meant their independence and autonomy was not developed and promoted as they had to ask permission to be let in and out of the service. The registered manager said that this was done to make sure people were safe and to make sure no strangers came into the house. People accepted this as it was the way it always been and had not been reviewed.

People were not always treated with dignity and respect that promoted their independence and autonomy. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interaction between people and staff was positive, caring and inclusive. Staff spoke with people in a friendly and pleasant manner. Staff consistently took care to ask permission before intervening or assisting. People, when possible, felt empowered to express their needs and received the care and support that they wanted in the way they preferred. Throughout the inspection exchanges between people and staff were caring, respectful and professional. People were included in conversations, staff explained things to people and took time to answer people's questions. People were very respectful and supportive towards each other. Positive and caring relationships had developed between people. Those who could not express their needs received the right level of support, for example, in managing their food and drink.

There was a calm atmosphere in the service. When people did become distressed or agitated, staff intervened and used appropriate de-escalation techniques, including listening and distraction skills. Most of the staff had good knowledge of people and their needs. Staff spoke about respecting people's rights and supporting people to make choices. Staff made sure that people were involved in their daily routines and did what they wanted to do and achieve during the day. Staff took time to listen and supported people to make arrangements for the day and when possible supported them to carry these out. Some people were going out shopping; others watched the television or did art and crafts.

Staff respected people's privacy and knocked on people's doors and waited to be invited in. When staff wished to discuss a confidential matter with a person they did not do so in front of other people but asked the person if they could speak to them in private. Everyone said their privacy was always respected.

People's rooms were personalised with their own possessions, they had their own things around them which were important to them. If people wanted they had a key to their bedroom door and were able to go to their bedrooms whenever they wanted. One person said, "I love my room. I have a big room and I can do what I want to in there. I have all my photograph's and important things in there".

There was personalised information about people's background and life events. Staff had knowledge about people's life history so they could talk to them about it and were aware of any significant events. People who were important to people like members of their family and friends were named in their care plan. This included their contact details and people were supported to keep in touch. People often went to visit their families and spend time with them and relatives and friends could visit people at the service at any time.

Confidential information about people was held securely. People who needed support to air their views were supported by their families or their care manager. People who needed support to make decisions about their care could be supported by the local advocacy service. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People's religious beliefs were supported. The service had developed links with local church groups and people attended church if they wanted to.

Requires Improvement

Is the service responsive?

Our findings

People told us that since some established staff had left there had been a period when they felt unsettled and were not sure what was 'going on'. They said that the situation was getting better as new staff had been employed and they were getting to know them. However, during the past months they had not felt involved as much as they used to with their care planning. One person said, "We used to sit down regularly with our key workers (Key workers were members of staff who take a key role in co-ordinating a person's care and support and promote continuity of support between the staff team) and discuss things, like what support we needed, what we wanted to do on our own and when we would need help. At the moment I am not sure who my key worker is but I can talk to any of the staff if I need anything".

The registered manager had fallen behind in reviewing and updating care plans. This was because the registered manager had spent time working alongside the care staff to make sure people received the care and support that they needed on a daily basis. Recently a member of staff had been employed to update and review the care plans. Some care plans had been re- written by staff who did not know people very well and the care plans did not contain the information about how to make sure people received the care and support the needed in a way that suited them best. People had not been involved in the review of their care plans.

Some care plans were written in a way that was not personalised. One care plan stated that a person's behaviour needed to be 'modified' and this will be done through being rewarded or punished by using cigarettes. This is not based on best practice guidance. The care plan did not explain to staff what action they had to take to make sure the person was supported and reassured. The care plan did not identify any triggers that might precede the behaviour. There was no positive behaviour support plan only negative instructions for staff to withdraw support and services. There was no indication that the person had been involved in writing the care plan or had agreed to it.

Another person had lived at the service for many years and needed support with their behaviour at times. The guidance given to staff was very vague and did not detail any strategies to redirect or distract the person. For example, it said things like, 'do not be confrontational unless you have to be.' There was limited detail about what triggers might lead the person to become distressed. There was no information about the early signs to look for or what action the staff needed to take to support the person in a way that suited them best.

The provider and registered manager had not provided person centred care that met people's needs with supporting care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At the last inspection in November 2015 people were not always treated with dignity and respect that promoted their independence and autonomy. People's care plans did not show any assessments that considered if people wished, were able, or could, with support, take control of their own medicines. At this inspection improvements had been made. People now had their own secure medicine cabinet in their bedrooms. Staff accompanied each person to their room to support them to take their medicines in private.

Staff said this was a much better way of giving people their medicines. They said people were treated as individuals and their dignity and privacy was respected. A more person centred approach had been adopted and personal choices were respected. The breach in the regulation had been met.

People had assessments before they came to stay at the service that were then reviewed and updated once people had arrived. The registered manager said that they took time to do this so they got to know people well first. Assessments reflected people's previous lifestyles, backgrounds and family life. It also included their hobbies, and interests, as well as their health concerns and medical needs. These helped staff to understand about people and the lives that they had before they came to live at Phoenix House. The assessments also included information about how people wanted to remain independent with specific tasks and the areas where they needed support. Staff asked people and their family members for details of their life so they could build up a 'picture' of the person.

People told us that they did not go out as much as they used to. They said, "We used to go out a lot more but not as much now, it's because there are new staff. I think it will get better". "We will go out more when the weather is warmer, we do quite a few things indoors but it can be a bit boring at times". Another person said they would like to be able to access and learn to use a computer but had not had the opportunity.

Staff said that activities outside the service were getting better again, but the mini bus had recently broken down and was being repaired. Also they said they were not so many drivers available now to take people out.

People told us they were able to make choices about their day to day lives and staff respected those choices. Everyone worked together to respond to people's individual needs to make sure people got the help and support they needed.

Staff said "We interact with the people who live here a lot; we take them out and do creative things with them. You need to offer stimulation and it's great to see their faces when they really enjoy something. We try to do whatever they ask if it can be done. You just have to listen".

People confirmed that when there were activities, they were supported and encouraged to take part in them. Some people could go out on their own and came and went as they pleased. Other people needed support when they went out. People said that they were encouraged to go outside the service and shopping trips, visits to local places of interest were arranged. There were links within the local community. People often went to the local pub for a drink or to the nearest town to do shopping or have a meal. People were supported to attend churches if they wished to do so.

People had recently had a pantomime and a Christmas party which they had enjoyed. At the time of the inspection people were planning and looking forward to Christmas.

We recommend that the provider source more innovative and creative activities for people that would support in developing their independence and skills.

A system to receive, record and investigate complaints was in place so it was easy to track complaints and resolutions. The complaints procedure was available to people and written in a format that people could understand. If a complaint was received this was recorded and responded to. Records showed the action that was taken to address the issue. The registered manager took all complaints very seriously, responded to them and tried to resolve the issue. People said that the registered manager and staff were approachable and said they would listen to them if they had any concerns. They told us they did not have any complaints

but would not hesitate to talk to the registered manager or staff if they did.

People said that they felt listened to and their views were taken seriously. If any issues were raised they said these were dealt with quickly. There were regular meetings for people and staff. There was a commitment to listening to people's views and making changes to the service when possible.

Inadequate

Is the service well-led?

Our findings

The previous inspection of this service was carried out on 3 November 2015 when we found breaches of some regulations. The provider sent an action plan to CQC in December 2015 with timescales stating they would be compliant with the regulations by December 2015. At this inspection the provider had failed to comply with their action plan and there were continued breaches of the regulations relating to the safe care and treatment of people, the recruitment of staff, treating people with dignity and respect that promoted their independence and autonomy and good governance. There was a further breach of the regulation relating to a lack of person centred care planning.

The registered manager had been covering shifts and working directly with people since some staff left. The provider had failed to ensure there was enough staff to meet people's needs which would allow the registered manager to carry out their managerial duties. The provider had failed to support the registered manager with managerial duties. Consequently the managerial duties had fallen behind. Staff had been recruited without the appropriate checks, care plans had been reviewed without people's involvement and consent. Records had been written in a way that was disrespectful and not based on good practice. People were bored and said they did not have much to do and there were imposed restrictions that had not been reviewed to make sure they were the least restrictive option. There continued to be shortfalls with the fire safety systems which placed people at risk.

At the previous inspection the registered manager and staff audited aspects of care both weekly and monthly such as medicines, care plans, health and safety, infection control, fire safety and equipment. People were at risk of receiving unsafe care and support because the audits had not identified the shortfalls that were found at the inspection.

At this inspection some audits had been completed but not always in line with the provider's policy, for example the health and safety monthly audits were only completed once in the last 12 months by the registered manager. These audits look at the environment and risks to people, there was a risk that issues could be over looked and not addressed. Staff carried out localised audits of areas such as the bathrooms and kitchens on a more regular basis.

Issues raised in audits were not always addressed by the provider, for example an audit completed on the emergency lighting showed two units needed replacing in October 2016. When we inspected in December 2016 only one unit had been changed and there was no planned date for the second to be completed. There was a risk that in the event of an emergency people would struggle to see where they were going. Staff told us that maintenance work often took a long time to be completed.

Audits had identified that care plans and risk assessments had not been updated and did not contain the information needed to make sure people received safe personalised care and support. When some of these had been updated the information and guidance for staff was inappropriate and lacking in detail so people were still at risk of not receiving the safe personalised care and support. This had not been identified as an issue as they had not been looked at by the registered manager.

The registered manager told us that for many months they had used their time in supporting people on a daily basis and working alongside the care staff to make sure people's daily basic needs were met. This had taken them away from their managerial duties. The registered manager said that they realised things had 'slipped' and had recognised the challenges of the service and was taking action to manage these. The provider had now agreed to employ agency staff to cover the staff shortfalls and new staff had been recruited or were in the process of being appointed.

Since the last inspection there had been a lack of improvements and development of the service.

The provider had failed to identify the shortfalls at the service through regular effective auditing. The service had not improved or developed. This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager that was supported by a new deputy manager and a team of care staff. People were able to approach the registered manager when they wanted to. Staff told us that the registered manager was available, accessible and they felt they could approach them if they had any concerns. Staff told us if they did have any concerns the registered manager acted quickly and effectively to deal with any issues. Staff said that they felt supported and valued by the registered manager and said that on the whole the staff team worked well together. The registered manager demonstrated a good knowledge of the people's needs.

The service's visions and values were to support and care for people and to keep them safe and to offer rehabilitation for the people it supports. The registered manager and staff were clear about some of the aims and visions of the service and did support people and keep them safe however there were limited opportunities for people to learn new skills or maintain skills they had previously developed.

We recommend that the registered persons develop and implement systems that support people with their rehabilitated in line with the provider's statement of purpose.

People were at the centre of the service and everything revolved around their needs and what they wanted. Our observations and discussions with people and staff at the service showed that there was an open and positive culture between people, staff and the registered manager.

When staff spoke about people, they were very clear about putting people first. The registered manager knew people well, communicated with people in a way that they could understand and gave individual and compassionate care. The staff team followed their lead and interacted with people in the same caring manner. Staff said that there was good communication in the staff team and that everyone helped one another.

Staff meetings were held regularly. Meetings were used to communicate any changes and updates to staff and allow staff the opportunity to discuss and raise any concerns or suggestions that they had.

The service sought feedback from people who used the service, their relatives, professionals and staff. The feedback was generally positive and any issues raised had been addressed. Relatives said, "I have complete confidence in the manager and her staff." "They support my relative in every way and anticipate their every need. They treat my relative with loving care, they are very happy living at Phoenix" and "Staff often try to improve my relative's quality of life." "My relative is respected, helped and liked by the staff. I am happy they are receiving good care and their diet has improved since going to Phoenix".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way. We had received notifications from the service in the last 12 months.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had not provided person centred care that met people's needs with supporting care plans. Regulation 9 (1)(2)(3)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect that promoted their independence and autonomy. Regulation 10 (1) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a risk that people's safety in the event of a fire may be compromised. Regulation 12 (2) (g) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to identify the shortfalls at the service through regular effective auditing. The service had not

improved or developed.

This was a breach of Regulation 17 (1) (2)(a) (b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information was available as required by Schedule three of the Regulations before new members of staff started work. This was a continued breach of Regulation 19 .